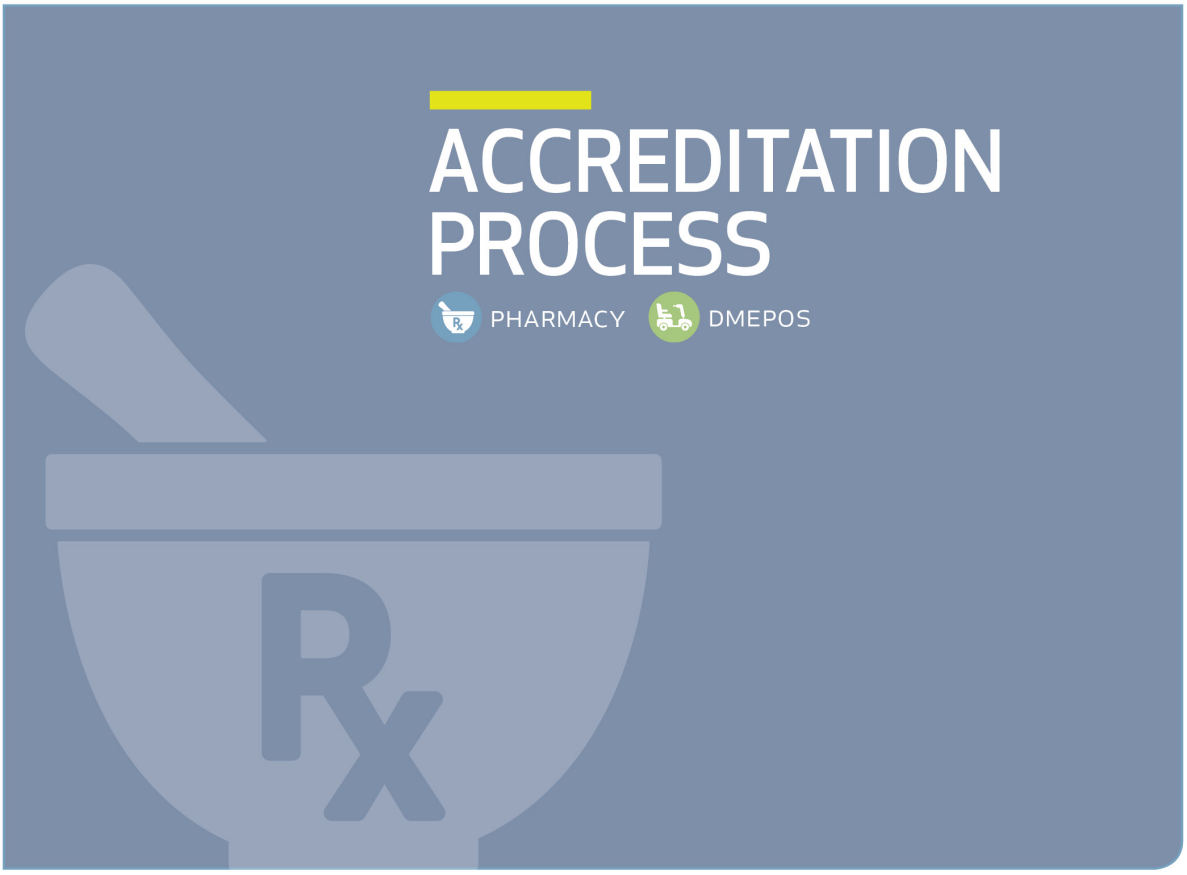


ACCREDITATION COMMISSION *for* HEALTH CARE

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## I. Introduction

Accreditation Commission for Health Care (ACHC) is an independent, 501(c)(3) nonprofit accrediting organization that is certified to ISO 9001:2015 standards. ACHC is governed by a volunteer Board of Commissioners (Board) that is composed of healthcare professionals and consumers. The Accreditation Process contained in this document pertain to all organizations, whether they are applying for accreditation for the first time, renewing accreditation, adding or eliminating branches, or adding or eliminating services. As a result of changes in industry standards and/or regulatory changes, as well as ACHC's continuous internal review of its processes, ACHC may update its Accreditation Process. Accordingly, ACHC's services will be furnished in accordance with the most current version of the ACHC Accreditation Process in effect on the date of the survey or in effect at the time of any other activity.

## II. Requirements

### A. Organization Types

**Noncorporate:** Non-corporate organizations are defined as having 24 or less physical locations.

**Corporate:** Corporate organizations are defined as having 25 or more physical locations.

NOTE: The Accreditation Process is written for noncorporate and corporate organizations unless otherwise specified. ACHC makes the final determination in defining a physical location.

### B. Eligibility Requirements

The organization may apply for accreditation if the following eligibility requirements are met.

The organization must:

1. Be currently operating within the United States and/or its territories
2. Have serviced a minimum of five clients/patients at the time of the survey. These customers can be cash sales or rentals to meet this requirement. ACHC waives this requirement if a state mandates accreditation before it can start serving patients.
3. Be licensed according to applicable state and federal laws and regulations and maintain all current legal authorization to operate.
4. Occupy a building in which services are provided/coordinated that is identified, constructed, and equipped to support such services (Note: Medicare providers need to reference the Medicare Supplier Standards).
5. Clearly define the services it provides directly or under contract.
6. Submit all required documents and fees to ACHC within specified time frames.
7. Meet all criteria for participation with Medicare/Medicaid if the organization is or plans to be a Medicare/Medicaid provider.

### C. ACHC DMEPOS and Pharmacy Program Services

#### 1. DMEPOS Program

a. **Home/Durable Medical Equipment (HME):** Home/Durable Medical Equipment services include the delivery, setup and/or maintenance of medical equipment and/or oxygen as well as education regarding the use of the equipment.

b. **Medical Supply Provider (MSP):** Medical Supply Provider services include the storage and delivery of medical supplies designed to meet the needs of the client/patient requiring products in the home care setting. The supplies are generally prescribed by a physician and are usually disposable or semi-durable in nature.

c. **Fitter (FS):** Fitter services include orthotic/prosthetic fitting of a variety of products such as diabetic shoes, soft orthotic appliances, and post-mastectomy breast prostheses.

d. **Complex Rehabilitation and Assistive Technology Supplier (RTS):** Complex Rehabilitation and Assistive Technology Supplier services are defined as the application of enabling technology systems designed to meet the specific needs of a person experiencing any permanent or long-term loss or abnormality of physical or anatomical structure or function. The equipment, prescribed by a physician, primarily addresses wheeled mobility, seating and alternative positioning, ambulation support and equipment, environmental control, augmented communication, and other equipment that assists the patient in performing daily living activities.

2. DMEPOS Program Distinction(s)

a. **Clinical Respiratory Patient Management (CRPM):** The Distinction in Clinical Respiratory Patient Management (CRPM) focuses on care by licensed Respiratory Care Practitioners (RCPs) or other qualified healthcare professionals for patients with acute or chronic respiratory conditions that can be monitored and managed outside a hospital environment. Emphasis is on a collaborative, team-based approach to assessment and ongoing treatment, disease management, and education. The goal is better clinical outcomes that reduce hospital readmissions, support activities of daily living, and enhance quality of life for the patient. Accountability is established through documentation of outcome-based measures, with the subsequent expectation of improving consistency of care and quality of life. This distinction must be achieved in combination with ACHC Home/Durable Medical Equipment (HME) Accreditation.

b. **Custom Mobility (CM):** The Distinction in Custom Mobility (CM) recognizes providers of custom mobility products who are committed to improving activities of daily living and health-related quality of life for clients/patients. Standards address the unique needs of clients/patients and focus on plans of care, goal and outcome monitoring, client/patient follow-up, and making product adjustments or replacements as needed to proactively reduce or prevent complications and maintain or improve mobility and daily life. Emphasis is on improved service and responsive care to clients/patients with conditions requiring mobility support, including 24/7 access to support. The goal is to sustain client/patient activities of daily living and overall quality of life through ongoing assessment of needs, proactive goal setting, and documentation. This distinction must be achieved in combination with ACHC Complex Rehabilitation and Assistive Technology Supplier (RTS) Accreditation.

3. Pharmacy Program

a. **Infusion Pharmacy (IRX):** Infusion Pharmacy services include IV drug mixture preparation, IV administration, therapy monitoring, client/patient counseling,

and education. It is the administration of medications using intravenous, subcutaneous and epidural routes. ACHC Infusion Pharmacy standards include sterile compounding, referencing USP <797>.

b. **Specialty Pharmacy (SRX):** Specialty Pharmacy services dispense medications (injectable, intravenous or oral) to a client/patient home, physician's office, or clinic specializing in certain disease states. These medications target a specific population with a chronic and sometimes life-threatening disease. Specialty Pharmacy includes disease specific clinical monitoring as well as patient compliance and adherence programs.

c. **Specialty Pharmacy Only (SRXONLY):** This service is for Specialty Pharmacies that DO NOT supply and/or bill for DMEPOS products as described by Medicare Part B coverage guidelines. If selected your survey can be coordinated and announced and ACHC WILL NOT report DMEPOS accredited product codes to the National Supplier Clearinghouse (NSC).

   **NOTE:** If you select this item in error and want to bill for DMEPOS product codes, another survey will need to be conducted, which will be unannounced and additional survey fees will apply.

d. **Infusion Nursing (IRN) (Non-Medicare Certified):**
   Infusion Nursing services involve the administration of parenteral medications via various accesses and ports provided by a qualified Registered Nurse (RN), Licensed Practical Nurse (LPN), or skilled professional, as allowed by state regulations, specifically trained in these specialized services. These services can be provided in a variety of settings. A Registered Nurse or Pharmacist is responsible for supervision of all IRN services.

   NOTE: IRN can be recognized for reimbursement by third-party payors and licensing boards. However, beginning in 2021, providers seeking to meet the Conditions for Coverage (CfCs) to receive Medicare reimbursement must be accredited under ACHC's Home Infusion Therapy Accreditation program.

e. **Long Term Care Pharmacy (LTC):** Long Term Care Pharmacy services manage medications for residents of institutional facilities to ensure proper drug therapy, as well as packaging and delivery of medications.

f. **Ambulatory Infusion Center (AIC):** Ambulatory Infusion Center services are centralized locations where a patient can receive infusion therapy administered by the appropriate clinical personnel.

g. **Community Retail (CR):** This accreditation only reviews the requirements to participate as a DMEPOS Medicare Part B provider. It is limited in the scope of products that are provided to a Medicare beneficiary. Community Retail services are provided in retail pharmacy stores that sell prescription medications and commonly used durable medical equipment and supplies to consumers.

h. **Mail Order Pharmacy (MORX):** Mail Order Pharmacies focus on the preparation of prescription medications delivered by qualified distribution methods directly to consumers. Pharmacies that undergo this accreditation demonstrate compliance with standards addressing: Pharmacy licensure, shipping methodology, patient and employee safety, prescription intake and

review, patient records and communication, personnel training, organizational oversight, and ongoing quality improvement.

4. **Pharmacy Program Distinction(s)**
    a. **Oncology (ONC):** Distinction in Oncology encompasses the delivery of medications for the treatment of cancer-specific conditions; the ability to identify the toxic nature of these medications; and collaboration between the physician, pharmacist, and client/patient to optimize the client's/patient's plan of care, cost containment, and client/patient outcomes. Organizations can apply for accreditation in a Distinction in Oncology only if they have achieved or are applying for ACHC Specialty Pharmacy Accreditation.
    b. **Infectious Disease Specific to HIV (HIV):** This additional recognition encompasses delivery of medications for the treatment of HIV, the ability to clearly manage client/patient adherence to these medications, collaboration between the physician, pharmacist, and client/patient to optimize the client's/patient's plan of care, cost containment, and outcomes. This distinction in HIV will show a clear, delineated dispensing and purchasing methodology. Organizations can apply for accreditation in a Distinction in Infectious Disease Specific to HIV only if they have achieved or are applying for ACHC Specialty Pharmacy Accreditation.
    c. **Hazardous Drug Handling (HDH):** The additional recognition demonstrates a commitment to meeting criteria set forth in USP Chapter <800> Hazardous Drugs – Handling in Healthcare Settings to promote patient and worker safety as well as environmental protection. HDH must be achieved in combination with ACHC or PCAB Pharmacy Accreditation.
    d. **Nutrition Support (NTS):** This additional recognition demonstrates a high level of competency in the provision of nutritional care. The provider must demonstrate a commitment to positive client/patient outcomes; provide an NTS team whose members possess advanced credentials; demonstrate the ability to clinically monitor clients/patients; assist with determining the optimal delivery of NTS formulas/products; provide assistance and recommendations to prescribers regarding the provision of NTS to clients/patients; assist with developing a plan of care for the client/patient; and assist with product selection and reimbursement. Organizations can apply for accreditation in a Distinction in Nutrition Support only if they have achieved or are applying for an ACHC Infusion Pharmacy Accreditation.
    e. **Rare Diseases and Orphan Drugs (RARE):** This additional recognition in Rare Diseases and Orphan Drugs encompasses processes and procedures necessary to bring a rare or orphan medication into market from FDA approval to patient management, employee education, and medication handling and dispensing. There must be a clear, and agreed upon, collaboration between the pharmacy and the manufacturer to provide optimal patient care with the ability to collect, analyze, report on, and act upon data collected during the patient treatment journey. Organizations can apply for accreditation in a Distinction in Rare Diseases and Orphan Drugs only if they have achieved or are applying for ACHC Specialty Pharmacy Accreditation.

## III. Principles Governing the Accreditation Survey

### A. Compliance

During the accreditation survey, ACHC determines whether the organization is meeting the intent of the ACHC Accreditation Standards. Proof of compliance is based upon items such as:

1. **Review of client/patient records**
2. **Personnel Files**
3. **Policies and Procedures**
4. **Observations**
5. **Interviews**

It is the organization's responsibility to ensure compliance with the ACHC Accreditation Standards at all times during the accreditation period. ACHC will release and communicate any updates/changes to ACHC Accreditation Standards every year on or around February 1. These updates/changes will have an effective date of June 1 of the same year in which they are released. However, in response to regulatory changes or requirements, ACHC Accreditation Standards may be updated at any time. Organizations must be compliant with any changes on the effective date.

### B. Education

While the organization is preparing for its survey, the organization's Account Advisor is available to provide assistance with the accreditation process. Clinical Managers are available for interpretation of ACHC Accreditation Standards or suggestions on how to implement them. During the survey, ACHC Surveyors will provide education and "best practice" suggestions to help the organization achieve optimum performance.

### C. Types of Surveys

All surveys listed below are unannounced, with the exception of the following surveys, which are announced:

- Corporate (all programs and services)
- Distinction in Oncology (all survey types)
- SRXONLY (all survey types)

1. **Initial Survey*:** An Initial Survey is conducted on organizations that apply for ACHC accreditation for the first time.
2. **Renewal Survey*:** A Renewal Survey is conducted on organizations that are currently accredited by ACHC. Renewal Surveys are conducted in the same format as an Initial Survey; however, during the Renewal Survey, the Surveyor also reviews previous deficiencies for compliance.
3. **Abridged Survey:** An Abridged Survey may be conducted on organizations that have multiple locations. Abridged Surveys are abbreviated to focus on a specific set of standards to verify compliance.
4. **Dependent Survey:** A Dependent Survey is a re-survey conducted on an organization that was not in compliance with ACHC Accreditation Standards.
5. **Corporate Survey:** A Corporate Survey is conducted on corporate organizations. Corporate Surveys provide the organization the opportunity to present policies

and procedures and other relevant information that demonstrate compliance with the ACHC Accreditation Standards.

6. **Initial Sampling Survey:** An Initial Sampling Survey is conducted for corporate organizations seeking ACHC accreditation for the first time. This survey takes place following the Corporate Survey to validate the information presented. An accreditation decision cannot be released until the Initial Sampling Survey(s) have been completed.
7. **Validation Survey:** A Validation Survey is for a corporate customer that takes place at least 30 days following the Corporate Survey. Validation Surveys will be conducted on a percentage of the organization's locations to verify compliance with the ACHC Accreditation Standards.
8. **Focus Survey:** A Focus Survey is conducted on organizations to ensure ongoing and continued compliance with the ACHC Accreditation Standards. Focus Surveys can take place anytime throughout the accreditation period or for any organizational changes.
9. **Complaint Survey:** A Complaint Survey is conducted on organizations that have a complaint filed against them. Should ACHC determine during the investigation that a site visit is required, ACHC will conduct a Complaint Survey to determine if the complaint is substantiated.
10. **Disciplinary Action Survey:** A Disciplinary Action Survey is conducted on organizations due to non-compliance from a previous survey, the ACHC Accreditation Standards and/or Accreditation Process and/or breach in the ACHC Accreditation Agreement. Disciplinary Action Surveys are unannounced.
11. **Virtual Survey*:** A Virtual Survey is conducted using a virtual hosting solution that allows an audio, video, and camera web-based platform for virtual meetings, including, but not limited to: GoToMeeting, Microsoft Teams, Skype, Webex, and Zoom. Virtual surveys are offered to certain organization types, depending on the parameters set by ACHC, state licensure requirements, and regulations of the Centers for Medicare & Medicaid Services (CMS). Virtual surveys review the same material as an on-site survey, and the organization needs to show compliance with all ACHC standards, and state and federal requirements. Virtual surveys can be announced or unannounced, depending on the program.

    *** Full survey:** This is a comprehensive survey examining all of the ACHC Accreditation Standards.

## IV. Accreditation Process before the Survey

### A. Register for access to ACHC through Customer Central

1. Access Customer Central through the ACHC website (www.achc.org).
2. Create username and password.

### B. Download ACHC Accreditation Standards

1. Available for organizations that have not previously obtained them.
2. Once purchased, organization has unlimited access to all ACHC Accreditation Standards.
3. Credit is applied for organizations that submit a deposit for accreditation.

### C. Complete ACHC Accreditation Application and Submit Deposit

1. Complete Accreditation Application in its entirety.
2. Complete statistical information for all physical locations. Based on governance, complexity of corporate structure, tax reporting, and other factors, ACHC will determine the number of applications and number of surveys required.
3. Submit nonrefundable deposit (applied toward accreditation fee).
4. Account Advisor is assigned to the organization.

### D. Execute Agreement for Accreditation Services

1. The following agreements outline the obligations of both ACHC and the organization. ACHC issues one of the following:
   a. Agreement for Accreditation Services/Business Associate Agreement (BAA)
   b. Agreement for Corporate Accreditation Services/ Business Associate Agreement (BAA)
2. Sign and return the Agreement and BAA to ACHC within the specified time frames listed on the cover page.
3. Failure to meet any terms of the Agreement or BAA may result in rescheduling or cancellation of the survey with fees assessed.

### E. Submission and Review of Preliminary Evidence Report (PER)

1. Attestation on PER checklist is completed confirming existence of required policies and procedures.
2. Upload required PER checklist and documents through Customer Central (contact Account Advisor if organization is unable to submit electronically).
3. ACHC evaluates the content of all required documents and the ACHC Surveyor will discuss any questions with the organization during the survey.
4. A review of all policies and procedures related to the ACHC Accreditation Standards is available to organizations for a fee.

### F. Scheduling

1. Upon receipt of the required PER documents, the scheduling process is initiated.
2. Organizations are allowed to choose up to 10 blackout days on which ACHC will not schedule a survey. Only two of these days can be Wednesdays. (NOTE: choosing fewer blackout dates provides greater flexibility in scheduling the survey.)
3. The following days do not need to be included in the organization's blackout days:
   a. New Year's Day
   b. Good Friday
   c. Memorial Day
   d. Independence Day
   e. Labor Day
   f. Thanksgiving Day and the following day
   g. Christmas Eve
   h. Christmas Day

4. ACHC reserves the right to send a Surveyor preceptee as part of the survey team. A preceptee is sent at no charge to the organization. All ACHC Surveyors/preceptees must disclose any potential conflict of interest with the organization to ACHC before they are assigned to conduct the survey. Surveyors/preceptees with a confirmed conflict are not utilized for the survey being scheduled.

### G. Postponement of Survey

1. Survey postponements must be requested in writing to the organization's Account Advisor. A call with a member of the clinical education team may be required.
   a. For an unannounced survey, organizations may request a survey postponement after their pre-survey call. If no pre-survey call is performed, organizations may request a survey postponement after their application is sent to scheduling by their Account Advisor. On the day of the survey, organizations must follow the refusal process.
   b. For an announced survey, organizations may request a survey postponement after their pre-survey call. If no pre-survey call is performed, organizations may request a survey postponement after their application is sent to scheduling by their Account Advisor. Starting the day before the survey, organizations must follow the refusal process.
   c. If a postponement request is accepted, ACHC will invoice a postponement fee as listed in the Agreement for Accreditation Services. The postponement fee is required to be paid prior to rescheduling the survey. The organization is responsible for notifying the Account Advisor in writing of its readiness for survey. When notified, the Account Advisor will proceed with rescheduling the survey following the ACHC scheduling process. If the organization does not notify the Account Advisor within 180 days of the postponement date, the organization's deposit and application may be forfeited and the organization must re-apply for accreditation.

## V. Survey Process

### A. Noncorporate Customers

1. **Opening Conference:** The opening conference may consist of the following based on the organizational structure:
   a. Introduction of the Surveyor(s)
   b. Review of the tentative schedule
   c. Review questions on any documents from the application process
   d. Q & A from the organization about the survey
2. **Tour of the organization**
3. **Data Collection**
   a. In order for ACHC to ensure that the organization is compliant with all ACHC Accreditation Standards, the survey focuses on the following:
      i. Personnel file review
      ii. Client/Patient record review
      iii. Financial/Billing records

iv. Service contracts
v. Risk management
vi. Performance Improvement activities
vii. Policies and procedures
viii. Observations
ix. Personnel and client/patient interviews

b. The organization authorizes ACHC to access the records listed above that are necessary to ascertain the degree of compliance with ACHC Accreditation Standards. ACHC complies with all HIPAA, privacy and security regulations.
c. The Surveyor's role is to review information presented and to clarify, observe, and verify data that supports compliance with applicable ACHC Accreditation Standards.

4. **Closing Conference**

The ACHC Surveyor conducts a closing conference with the organization's representatives.

a. This allows a final opportunity to clarify information or present data that may not have been reviewed by the Surveyor during the survey.
b. The ACHC Surveyor will provide organizational strengths and deficiencies.
c. The ACHC Surveyor does not issue an accreditation decision at the completion of the survey.

**B. Corporate Customers**

1. **Corporate Survey:** Corporate organizations that do not provide patient services out of the corporate office will have an announced Corporate Survey that will include the following:
   a. Opening conference led by ACHC
      i. Introduction of the survey team
      ii. Introduction of the organization's personnel
      iii. Review of the day's schedule
   b. Tour of the organization, if applicable
   c. Q&A from the organization about the survey
   d. Presentation of the organization's policies and procedures as required by the ACHC Accreditation Standards
   e. Review of questions on any documents from the application process
   f. Review of corporate officer/senior management personnel records maintained at corporate office
   g. Presentation of the organization's Performance Improvement Plan and results of the ongoing monitoring
   h. Interviews with the corporate management personnel
   i. Closing conference
2. Following the Corporate Survey for new corporate organizations, the ACHC survey team will conduct Initial Sampling Surveys on a specified number of locations to

verify compliance with the ACHC Accreditation Standards. Once the Initial Sampling Surveys are completed, the data collected will be sent back to the organization's Account Advisor for processing. An organization's accreditation decision cannot be determined until the Initial Sampling Surveys are completed. Initial Sampling Surveys are conducted in the same format as the non-corporate survey process.

3. At least 30 days following the Corporate Survey, ACHC will begin conducting unannounced Validation Surveys on a percentage of the remaining locations. These surveys verify that the information presented during the Corporate Survey is being followed and meets the ACHC Accreditation Standards. Validation Surveys are conducted in the same format as the non-corporate survey process.

### C. Refusal of Survey

1. Organizations have the right to refuse an ACHC survey.
   a. Announced surveys can be refused starting the day before the survey. Unannounced surveys can be refused the day of the survey. If an organization wishes to request a survey refusal, it must contact its Account Advisor and complete a Survey Refusal Form. A call with a member of the clinical education team may be required.
   b. If an ACHC Surveyor arrives on site and the organization wishes to refuse, does not meet the eligibility criteria for an accreditation survey, or is not in operation during its posted business hours, the Surveyor will notify the Account Advisor of refusal. A call with a member of the clinical education team may be required. If possible, a Survey Refusal Form will be completed on site.
   c. If an ACHC survey is refused, ACHC will invoice a refusal fee as listed in the Agreement for Accreditation Services. The refusal fee is required to be paid prior to rescheduling the survey. The organization is responsible for notifying the Account Advisor in writing of its readiness for survey. When notified, the Account Advisor will proceed with rescheduling the survey following the ACHC scheduling process. If the organization does not notify the Account Advisor within 180 days of the refusal date, the organization's deposit and application may be forfeited and the organization must re-apply for accreditation.

## VI. Accreditation Process Post Survey

### A. Reviewing the Data Collected

1. **Scoring:** Following the conclusion of the accreditation survey, the ACHC Surveyor will submit all of the data collected to the organization's Account Advisor for processing. The information is entered into an electronic tool that provides objective data for determining the accreditation decision.
2. **Preparing the Summary of Findings:** The Summary of Findings is prepared describing all ACHC Accreditation Standards that were marked as a deficiency during the accreditation survey. Each ACHC Standard for Accreditation marked as a deficiency will contain an "Action Required" statement. This will assist the organization in preparing a Plan of Correction (POC) to meet the ACHC Accreditation Standards. Surveyors may include any "best practice" suggestions in their summary as additional education. These best practice suggestions are not mandatory for the organization but are recommendations for improvement.

3. **Accreditation Review:** All Summary of Findings that result in a denial decision are analyzed by the appropriate Clinical Manager or designee and evaluated by a minimum of one other appropriate individual to ensure consistency before the denial decision is rendered.

**B. Accreditation Decisions**

1. **Approval of Accreditation:**
   - **a.** Accreditation is Approved based on the following criteria:
     - **i.** Results of the data collected during survey
     - **ii.** Number and/or severity of deficiencies
     - **iii.** Clinical Manager/designee review
   - **b.** A Plan of Correction (POC) is required for any ACHC Accreditation Standards not fully met. The POC is due to ACHC within 30 days from the date of the organization's Approval letter with necessary supporting documentation. A Certificate of Accreditation will not be sent to the organization until the POC has been approved by ACHC.
   - **c.** The accreditation effective date for new and renewal organizations that receive an Approval of Accreditation is determined as follows:
     - **i. New Organization:** The accreditation effective date is the last day of survey.
     - **ii. Renewal Organization:** The accreditation effective date will continue for an additional 36 months from the previous accreditation expiration date if the Renewal Survey is conducted prior to the expiration date. If the organization's survey takes place after the expiration date, the approval date will start from last date of survey (Section VI, G, 2).
2. **Accreditation Pending:**
   - **a.** Accreditation Pending is based on the following criteria:
     - **i.** Results of the data collected during survey
     - **ii.** Number and/or severity of deficiencies
     - **iii.** Clinical Manager/designee review
   - **b.** A Plan of Correction (POC) is required for any standards not fully met. The POC is due to ACHC within 30 days from the date of the organization's Accreditation Pending letter with necessary supporting documentation. Failure to submit evidence may result in the organization being designated as Under Review (Section VII, A).
   - **c.** All POCs are reviewed by the Clinical Manager/designee. After reviewing the POC ACHC may issue:
     - **i.** Approval of Accreditation
     - **ii.** A rejection of POC and require additional information
     - **iii.** Dependent Status (Section VI, B, 3)
   - **d.** Following the review of the POC, if accreditation is granted, the effective dates for new and renewal organizations are determined as follows:
     - **i. New Organization:** The effective date is the day the approved

POC is received by ACHC. An approved POC is one that has been accepted by the Clinical Manager/designee.

ii. **Renewal Organization:** The accreditation effective date will continue for an additional 36 months from the previous accreditation expiration date if the Renewal Survey occurs and acceptable POC is received prior to the expiration date. If the organization's survey takes place after the expiration date, the approval date will start from the date the acceptable POC was received (Section VI, G, 2).

3. **Dependent Status:**
   a. Dependent Status is determined based on the following criteria:
      i. Results of the data collected during survey
      ii. Number and/or severity of deficiencies
      iii. Clinical Manager/designee review
   b. The POC is due to ACHC within 30 calendar days from the date of the Dependent Status letter. The organization must submit written notification to ACHC of its readiness for a Dependent Survey, at the organizations expense, within 90 days of the date of the dependent letter. If the organization fails to notify ACHC within 90 days, the decision will move to a Denial of Accreditation.
   c. The Surveyor submits the findings from the Dependent Survey to the organization's Account Advisor and a decision will be made by the Clinical Manager/designee. Upon review ACHC may issue:
      i. Approval of Accreditation
      ii. Accreditation Pending
      iii. Denial of Accreditation (Section VI, B, 4)
   d. Following a Dependent Survey, if accreditation is granted, the effective accreditation dates for new and renewal organizations are determined as follows:
      i. **New Organization:** The effective date of accreditation is the last day of the Dependent Survey if no deficiencies are identified. If deficiencies are identified during the Dependent Survey, the effective date of accreditation is the day the approved POC is received by ACHC from the Dependent Survey. An approved POC is one that has been accepted by the Clinical Manager/designee.
      ii. **Renewal Organization:** The accreditation effective date will continue for an additional 36 months from the previous accreditation expiration date if the Dependent Survey occurs and acceptable POC is received prior to the expiration date. If the organization's survey takes place after the expiration date, the Approval date will start from the date the acceptable POC is received (Section VI, G, 2).
4. **Denial of Accreditation:**
   a. Denial of accreditation is based on the following factors:
      i. Results of the data collected during survey
      ii. Number and/or severity of deficiencies

iii. A minimum of two Clinical Manager/designees review decision

b. If accreditation is Denied, the organization has the option to appeal the decision by following the steps outlined in the Appeals Process (Section VI, E)

c. If Accreditation is Denied, the organization has the opportunity to re-apply for Accreditation at any time they are ready for survey. At the time of re-application, a new application must be submitted with a non-refundable deposit. ACHC will make the determination whether a new PER is required.

### C. Validation Survey Results for Corporate Organizations

1. Corporate organizations that receive a Corporate Survey will follow the same criteria as listed above to determine an accreditation decision. New corporate organizations will receive a minimum of one Initial Sampling Survey before an accreditation decision can be issued.
2. Once a final decision has been issued to a corporate organization and all of its locations, the Validation Surveys will result in one of the following:
   a. **Continued accreditation with no deficiencies:** If no deficiencies were found during a Validation Survey, a POC is not required and the accreditation dates will remain in effect with the corporate accreditation.
   b. **Continued accreditation with deficiencies:** If minimal deficiencies are found during a Validation Survey, a POC with necessary supporting documentation is required within 30 days from receipt of the notification letter. The accreditation dates will remain in effect with the corporate accreditation.
   c. **Focus Survey:** If the scope and severity of deficiencies are significant during the Validation Survey, a Focus Survey may be required in order for the accreditation to stay in effect. A POC with necessary supporting documentation is required within 30 days from receipt of the notification letter and a Focus Survey will be scheduled for this location at the organization's expense. Following the Focus Survey, if the location is found to be in compliance, accreditation dates will remain in effect with the corporate accreditation. Following the Focus Survey, if the location is found to be out of compliance, the location may be placed Under Review (Section VII, A).
   d. **Removal of accreditation:** After being placed Under Review, if the location is still found to be out of compliance with the ACHC Accreditation Standards, ACHC may terminate the accreditation for that location (Section VII, B).

### D. Accreditation Documentation

1. Once an accreditation decision is made by the Clinical Manager/designee the accreditation decision is given to the Account Advisor. The Account Advisor then prepares the proper documentation to send to the organization.
2. Based on the Accreditation decision, the Account Advisor sends the following:
   a. **Approval of Accreditation with No Deficiencies:** Accreditation Approval letter, Certificate of Accreditation, addendum, state form, Summary of Findings and window decal
   b. **Approval of Accreditation with Deficiencies:** Accreditation Approval letter, addendum, state form, Summary of Findings and Plan of Correction Template

- Certificate of Accreditation and window decal will be sent to the organization when the completed POC and evidence is approved by ACHC

c. **Accreditation Pending:** Accreditation Pending letter, addendum, state form, Summary of Findings, and Plan of Correction Template
   - Certificate of Accreditation and window decal will be sent to the organization when the completed POC and evidence is approved by ACHC

d. **Dependent Status:** Dependent Status letter, Summary of Findings, and Plan of Correction Template

e. **Denial of Accreditation:** Denial letter and Summary of Findings

3. The POC must be completed in its entirety, returned to ACHC, and approved by the Clinical Manager/designee in order to be acceptable. The POC must be completed on the ACHC Plan of Correction Template and must contain the following elements:
   a. The standard that was out of compliance
   b. Corrective action to be taken
   c. Implementation date
   d. Title of individual responsible
   e. Process for continued compliance
4. Once an organization receives an Approval decision, the organization's accreditation information can be found on the ACHC website for verification.

### E. Dispute Process

Organizations, whether applying for the first time or renewing their accreditation, may formally request to dispute a standard(s) deficiency documented on the Summary of Findings. If a company wants to dispute a denial decision, they must follow the appeal process (refer to Section VI. F).

The procedure to dispute a standard(s) deficiency is as follows:

1. The organization submits a written request for dispute to its ACHC Account Advisor no later than 30 calendar days from the receipt of the Summary of Findings. Disputes will not be granted if:
   a. The request is received after the 30 calendar day timeframe
   b. An organization has an outstanding balance
   c. An organization has a payment plan that is not current
2. The written request outlines the standard(s) noted in the Summary of Findings that the organization believes ACHC incorrectly determined as a deficiency. The organization must also provide evidence to support that, at the time of the survey, the organization was in compliance with the standard(s). Any evidence the organization submits must have been presented to and reviewed by the Surveyor(s) at the time of the survey. Evidence provided with the request letter will not be returned to the organization.
3. Upon receipt of the request for a dispute, ACHC sends an acknowledgement letter to the organization

4. If the organization is required to submit a Plan of Correction (POC) as a result of its survey, the organization must indicate on the POC any standard(s) deficiency being disputed.
5. The ACHC Review Committee will evaluate and determine whether ACHC followed its stated Accreditation Process in conducting the organization's accreditation survey.
6. Any ACHC Review Committee member who has a conflict of interest with the organization under review refrains from voting on the dispute.
7. Upon completion of the review, the ACHC Account Advisor notifies the organization of the ACHC Review Committee's decision to either uphold or reverse the original standard(s) deficiency noted on the Summary of Findings.
8. All decisions made by the ACHC Review Committee are final.

### F. Appeal Process

Organizations, whether applying for the first time or renewing their accreditation, may formally request to appeal a Denial decision. The procedure to appeal a Denial of Accreditation is as follows:

1. The organization submits a written request for appeal to its ACHC Account Advisor no later than 30 calendar days from the date on ACHC's Denial letter. Appeals will not be granted if:
   a. The request is received after the 30 calendar day timeframe
   b. An organization has an outstanding balance
   c. An organization has a payment plan that is not current
2. The written request outlines the standard(s) noted in the Summary of Findings that the organization believes ACHC incorrectly determined as a deficiency. The organization must also provide evidence to support that, at the time of the survey, the organization was in compliance with the standard(s). Any evidence the organization submits must have been presented to and reviewed by the Surveyor(s) at the time of the survey. Evidence provided with the request letter will not be returned to the organization.
3. Upon receipt of the request for an appeal, ACHC sends an acknowledgement letter to the organization.
4. The ACHC Appeals Committee, which is composed of a minimum of three individuals who have clinical and/or program expertise, will evaluate and determine whether ACHC followed its stated Accreditation Process in conducting the organization's accreditation survey.
5. Any ACHC Appeals Committee member who has a conflict of interest with the organization under review refrains from voting on the appeal.
6. Upon completion of the review, the ACHC Account Advisor notifies the organization in writing of the ACHC Appeals Committee's decision to either uphold or reverse the original Denial decision.
7. All decisions made by the ACHC Appeals Committee are final.

### G. Continued Compliance

1. Accreditation is contingent upon continued compliance with the ACHC Accreditation Standards and the Accreditation Process. After an organization is granted accreditation, ACHC reserves the right to make unannounced Focus Survey visits at any time during the accreditation period to ensure continued compliance with the ACHC Accreditation Standards.
2. If a Focus Survey reveals non-compliance with any ACHC Accreditation Standards, a POC and supporting documentation will be required. Based on the number and/or severity of deficiencies, the organization may be invoiced for the Focus Survey.

### H. Renewing Accreditation

1. Accreditation is not automatically renewable. Approximately 12 months prior to the organization's expiration of accreditation, ACHC will notify the organization about the renewal process.
2. If the organization's renewal application, PER and deposit are not submitted by the required due date listed on the renewal letter, sufficient time may not exist to schedule and complete a survey prior to the accreditation expiration date.
3. In the event an organization's accreditation expires, the organization's accreditation information will be removed from the accredited organization list located on the ACHC website.

## VII. Disciplinary Actions

Disciplinary actions can come from a nonconformance resulting from an ACHC survey and/or failure to remain in compliance with ACHC survey and/or failure to remain in compliance with ACHC Accreditation Standards, Accreditation Process, and/or a breach in the ACHC Accreditation Agreement.

### A. Non-Compliance Process

1. The organization may be placed Under Review:
    a. ACHC notifies customer
    b. ACHC determines which of the following actions will be taken:
        i. ACHC may request written documentation
        ii. ACHC may conduct a Disciplinary Action Survey
        iii. If ACHC determines that Immediate Jeopardy might be present, the process as described in Section X.C will be followed
        iv. ACHC may require a Plan of Correction be completed
        v. ACHC may require payment
    c. Upon review of any documentation or Plan of Correction, ACHC may accept it, reject it or require additional information
    d. ACHC will render a decision
        i. Continuance of Accreditation
        ii. Accreditation remains Under Review
        iii. Termination

2. Accreditation may be terminated based on the number or severity of nonconformance or if it is believed that compliance with ACHC standards is not possible within a reasonable timeframe.

**B. Termination**

Organizations accredited by ACHC must remain in compliance with ACHC Accreditation Standards; adhere to local, state and federal legal requirements; ensure the safety of their patients and staff; and meet commonly held standards of professional ethics and conduct.

Accreditation can be terminated any time during the accreditation cycle. A decision to terminate accreditation does not need to be preceded by a survey because problems with an organization's services can become apparent from a number of other sources. Therefore, if ACHC receives evidence of noncompliance with ACHC Accreditation Standards or other pertinent criteria, ACHC may decide to terminate accreditation if, in its judgment, it finds that one or more of the following conditions are present:

1. An immediate threat exists to patient safety, public health or staff safety. Such an immediate threat can arise from one incident on a single occasion that affects a single patient, a single staff member or a single member of the public.
2. ACHC determines, in its discretion, that the scope or severity of the organization's noncompliance with ACHC Accreditation Standards is so significant that it is infeasible for the organization to complete corrective action within 10 calendar days or within a reasonable time frame, as ACHC determines in its discretion under the circumstances.
3. The organization fails to comply or fails to maintain compliance with CMS Conditions of Participation, Conditions for Coverage (CfC), CMS Supplier Standards or CMS Quality Standards.
4. The organization falsifies documents or misrepresents information in seeking to achieve or retain accreditation, or in seeking or retaining some other license, certification, or authorization to operate, or to receive payment for services.
5. The organization, or a staff member, engages in any criminal conduct involving a felony, or engages in immoral, unethical, dishonest, incompetent or other unprofessional behavior that significantly adversely affects, or has the potential to significantly adversely affect, the safety or welfare of any patient or client, or the safe and effective delivery of the organization's services.
6. The organization does not fulfill contractual obligations during the accreditation cycle by failing to comply with post-accreditation obligations, as specified in the Agreement for Accreditation Services.

## VIII. Notification of Changes

ACHC requires organizations to provide the required documentation described below within 30 days of a change occurring. Changes include branch office addition or deletion, service addition or deletion, change in the name, location, ownership or control of the organization. Failure to submit the required documentation within the 30-day timeframe may result in a gap in accreditation.

**A. Name Changes**

1. If an organization goes through a name change, the organization must notify ACHC of the change within 30 days of the change. The organization must complete and submit the Change of Name form that can be downloaded from Customer Central. The form is located under the "Forms" tab. Select "Name Change," then the corresponding Change of Name Request Form. This form can be completed electronically using an e-signature.
2. After ACHC approves the name change, complete the following:
   a. Submit your 855S form with the new name to the NSC
   b. Upon receipt of the "Information Change Approval" letter from the NSC, submit a copy to your ACHC Account Advisor.
3. ACHC may request additional documentation upon review. If approved, ACHC will issue a new accreditation certificate.
4. If it is determined a survey is necessary, the normal unannounced survey scheduling process will apply and the organization is charged a survey fee.
5. If the organization is found to have substantial deficiencies during the survey, the accreditation for that location and/or the organization as a whole is reviewed by the Clinical Manager/designee and the Accreditation Review Committee. Following the review, the organization may be placed in Under Review.

**B. Location Change**

1. If an organization goes through a location change, the organization must notify ACHC of the change within 30 days of the change. The organization should complete and submit the Change of Location form that can be downloaded from Customer Central. The form is located under the "Forms" tab. Select "Change of Location," then the corresponding Change of Location Request Form. The form can be completed electronically using an e-signature.
2. After ACHC approves the location change, complete the following:
   a. Submit your 855S form with the location change to the NSC
   b. Upon receipt of the "Information Change Approval" letter from the NSC, submit a copy to your ACHC Account Advisor.
3. ACHC may request additional documentation upon review. If approved, ACHC will issue a new accreditation certificate for any address changes outside the original city and state.
4. If it is determined a survey is necessary, the normal unannounced survey scheduling process will apply and the organization is charged a survey fee.
5. If the organization is found to have substantial deficiencies during the survey, the accreditation for that location and/or the organization as a whole is reviewed by the Clinical Manager/designee and the Accreditation Review Committee. Following the review, the organization may be placed in Under Review.

**C. Cessation or Interruption within the Organization**

1. If the organization has a cessation or interruption of all operations, offering of service and/or a deletion of any service that has received accreditation, the organization must notify ACHC via a notification letter. The organization's notification letter to ACHC must include the following:

   a. Effective date of the cessation or interruption
   b. Detailed description of the reason for the cessation or interruption
2. Upon receipt of the written notification, ACHC will review and send an acknowledgment to the organization. The notification letter is placed in the organization's file. ACHC may request additional documentation before an acknowledgement letter is sent.
3. The organization notifies ACHC of any change in the status from the acknowledgment of the cessation or interruption of operations. Upon notification, ACHC will review the organization's accreditation status and determine if a survey is required to ensure compliance with the ACHC Accreditation Standards.

**D. Branch Office Addition**

1. Any addition of a physical location added to an accredited provider must go through the branch addition process. The organization must complete and submit a Branch Addition Packet. The packets are located on Customer Central under the "Forms" tab and can be downloaded. The Branch Addition Packet must be completed in full, including all sections and any additional documentation listed on the form.
2. A review of the documentation is performed and any missing information is requested from the organization in writing. Additional information may be requested prior to approving the branch addition. ACHC holds the branch addition documentation without further processing until the missing information is received from the organization. Once all required documentation has been submitted, the appropriate Clinical Manager/designee reviews the submitted documentation and a decision is made whether a survey is warranted.
3. Upon approval of the submitted documentation, ACHC issues accreditation based on the date that all required documentation was submitted. ACHC will not back date an accreditation for any organization that sends notification after the branch opening. All fees must be paid in full before ACHC issues any accreditation documentation.
4. ACHC will conduct surveys for all locations meeting the definition of a practice site. A practice site is defined as a location a client/patient can visit for service, education, and/or to pick up or return equipment or supplies. The normal unannounced survey scheduling process will apply and organizations will be charged the current customary branch addition fees. ACHC reserves the right to conduct a focus survey of any warehouse, call center, or administrative location addition. If it is determined that an on-site review is not necessary, the organization may be charged the branch addition fee indicated in the Accreditation Agreement.
5. If the organization is found to have substantial deficiencies during the site survey, the accreditation for that location and/or the organization as a whole is reviewed by the Clinical Manager/designee and the Accreditation Review Committee. Following the review, the organization may be placed in Under Review.

**E. Service Addition**

1. Organizations that request to add a new service to an already accredited program must complete and submit a Service Addition Packet. The packet can be downloaded from Customer Central and is located under the "Forms" tab. Select "Change Services," then the corresponding Service Addition Packet. The Service Addition Packet must be completed in full, including all sections and any additional documentation listed on the form.
2. A review of the documentation is performed and any missing information is requested from the organization in writing. ACHC holds the service addition documentation without further processing until the missing information is received from the organization. Additional information may be requested prior to approving the service addition. Once all required documentation has been submitted, the appropriate Clinical Manager/designee reviews the submitted documentation and an accreditation decision is made whether a survey is warranted. A survey is based on several factors that include the original survey findings, where the organization is in the three -year accreditation cycle, and how many locations have been added from the start of its accreditation.
3. Upon approval of the submitted documentation, ACHC issues accreditation based on the date that all required documentation was submitted. ACHC will not back date an accreditation for any service addition. All fees must be paid in full before ACHC issues any accreditation documentation.
4. If it is determined a survey is necessary, the normal unannounced survey scheduling process will apply and the organization is charged a survey fee. If it is determined a survey is not necessary, the organization will be charged the service addition fee indicated in the Accreditation Agreement.
5. If the organization is found to have substantial deficiencies during the survey, the accreditation for that location and/or the organization as a whole is reviewed by the Clinical Manager/designee and the Accreditation Review Committee. Following the review, the organization may be placed in Under Review.

**F. Product Code Category Addition**

1. Organizations that request to add a new product code category to an already accredited service must complete and submit a Product Code Addition Packet. The packet can be downloaded from Customer Central and is located under the "Forms" tab. Select "Change Product Codes," then the "DMEPOS RX Product Code Addition Packet." The Product Code Addition Packet must be completed in full, including all sections and any additional documentation listed on the form.
2. A review of the documentation is performed and any missing information is requested from the organization in writing. Additional information may be requested prior to approving the product code addition. ACHC holds the product addition documentation without further processing until the missing information is received from the organization. Once all required documentation has been submitted, the appropriate Clinical Manager/designee reviews the submitted documentation and a decision is made whether a survey is warranted.
3. Upon approval of the submitted documentation, ACHC issues accreditation based on the date that all required documentation was submitted. ACHC will not back

date an accreditation for any product addition. If a survey is required all survey fees must be paid in full before ACHC issues any accreditation documentation.

4. If it is determined a survey is necessary, the normal unannounced survey scheduling process will apply and the organization is charged a survey fee. If it is determined that a survey is not necessary, there will be no charge to the organization.
5. If the organization is found to have substantial deficiencies during the survey, the accreditation for that location and/or the organization as a whole is reviewed by the Clinical Manager/designee and the Accreditation Review Committee. Following the review, the organization may be placed in Under Review.

**G. Ownership or Ownership Information Changes**

1. The following process is followed when an organization has an ownership or ownership information change of 5% or greater, such as:
   a. Stock transfer
   b. Asset purchase
   c. Acquisition
   d. Merger
   e. Consolidation
2. The following information is submitted to the organization's ACHC Account Advisor by the proposed new owner.
   a. Letter of attestation that includes:
      i. Type of change (e.g., acquisition, merger)
      ii. Detail of all changes including new management and/or owner
      iii. Proposed date of change
      iv. Statement that policies and procedures are not changing, or, if they are changing, what are the specific changes
      v. List old and new federal tax ID numbers and NPI numbers, if applicable
      vi. Who the new contacts will be, including owner, leader, and liaison, and the phone numbers and email addresses for each
   b. Documentation that includes:
      i. Completed Additional Site Information form
      ii. DMEPOS Addendum
      iii. State Licensure Verification form
      iv. Proof the new owners/managers/agency is not on the OIG exclusion list
      v. New organizational chart
      vi. Upon receipt of the acknowledgement letter from the NSC, the organization should submit a copy to ACHC.
3. A review of the documentation is performed and any missing information is requested from the organization in writing. ACHC holds the documentation

without further processing until the missing information is received from the organization. Once all required documentation has been submitted, the appropriate Clinical Manager/designee reviews the submitted documentation.

4. Upon approval of the submitted documentation, ACHC issues accreditation based on the date that all required documentation was submitted. If a survey is required, the normal unannounced survey scheduling process and fees will apply. If it is determined that a survey is not necessary, the organization will be charged the fee indicated in the Accreditation Agreement.
5. After ACHC approves the change of ownership, the organization should:
   a. **Submit an updated 855S to the NSC**
   b. **Upon receipt of the NSC acknowledgement letter, submit a copy to ACHC**
6. If the organization is found to have substantial deficiencies during the survey, a Plan of Correction will be required and/or a follow up Focus Survey may be required.

## IX. Public Information

### A. Logo/Advertising Language

An organization must accurately describe only the program(s), service(s) and branch office(s) currently accredited by ACHC and abide by the ACHC Logo Usage Guidelines when displaying accreditation status using ACHC's logos or ACHC's name. False or misleading advertising represents noncompliance with ACHC Accreditation Process and will result in penalties up to and including termination of accreditation. The ACHC Logo Usage Guidelines are available on the organization's Customer Central website. Branch programs and services accredited during the accreditation cycle cannot be advertised as accredited until appropriate accreditation certificates are issued by ACHC.

### B. Press Releases

ACHC encourages organizations to publicize their accreditation status. Publicity tips and a sample press release are available to approved organizations on Customer Central.

## X. Nonconformance Policy

### A. Handling of Complaints

As required by ACHC Accreditation Standards, accredited organizations must provide ACHC's telephone number to their clients/patients as part of their patient informational material for purposes of reporting a complaint. If complaints cannot be resolved through the organization's complaint process, patients may file a complaint with ACHC. These complaints should identify facts or circumstances that relate to the complaint. ACHC documents and investigates all complaints/allegations received against currently accredited organizations. ACHC follows CMS Complaint Procedure guidelines for conducting investigations and records of complaints are maintained. ACHC will investigate and maintain records on complaints from any source when an ACHC accredited organization appears to be out of compliance with its ACHC Accreditation Standards.

1. Complaint should include:

a. Name, mailing address and phone number of the person filing the complaint
b. Name of the organization involved
c. A detailed description of the incident that is the subject of the complaint, including identification of date, time, and location of each incident, as well as the identity of other individuals with information about the incident.

2. While under investigation by ACHC, a complaint is a confidential matter. However, ACHC cannot guarantee complainants that their identity will remain confidential if the organization determines the identity based on their own internal methods/investigation.

**B. Processing a Complaint**

ACHC will determine the severity and urgency of the allegations so that appropriate and timely action can be taken. Comprehensive information is collected during the Intake Process. Quality Assurance or an appropriate designee enters pertinent information into the complaint database and then discusses the complaint with the appropriate Clinical Manager who is professionally qualified to evaluate the allegations to ensure that patients are not in danger of abuse, neglect, exploitation, and inadequate care, or supervision.

**C. Immediate Jeopardy (IJ)**

IJ is defined as: "A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a patient." (42 CFR Part 489.3) Complaints are assigned this priority if the alleged noncompliance indicates there was serious injury, harm, impairment or death of a patient or resident, or the likelihood for such, and there continues to be an immediate risk of serious injury, harm, impairment or death of a patient or resident unless immediate corrective action is taken. The identification and removal of IJ, either psychological or physical, are essential to prevent serious harm, injury, impairment, or death for individuals.

1. In accordance with the Medicare State Operations Manual Appendix Q, ACHC acknowledges the following principles of IJ, including:
   a. Only one individual needs to be at risk. Identification of IJ for one individual will prevent risk to other individuals in similar situations.
   b. Serious harm, injury, impairment, or death does not have to occur before considering IJ. The high potential for these outcomes to occur in the very near future also constitutes IJ.
   c. Individuals must not be subjected to abuse by anyone including, but not limited to the organization's personnel, consultants or volunteers, and family members or visitors.
   d. Serious harm can result from both abuse and neglect.
   e. Psychological harm is as serious as physical harm.
   f. When a Surveyor has established through investigation that a cognitively impaired individual harmed an individual receiving care and services from the organization due to the organization's failure to provide care and services to

avoid physical harm, mental anguish, or mental illness, this should be considered neglect.

g. Any time a team cites abuse or neglect, it should consider IJ.

2. ACHC will conduct an unannounced survey on the organization to investigate the issues within two business days of receipt of the allegations.
3. If Immediate Jeopardy has been identified, a verbal notice is given to the entity, including the specific details and individuals at risk. If corrective measures have not already been implemented, the entity should begin immediate removal of the risk and immediately implement corrective measures to prevent repeat jeopardy situations. Only on-site observation of the entity's corrective actions justifies a determination that an Immediate Jeopardy has been removed.
4. A formal written report is then prepared to reflect the above findings and submitted to ACHC within two business days of completion of the onsite review. Documentation is forwarded to and reviewed by the Clinical Compliance Department and Accreditation Review Committee and a final report of findings is sent to the organization within ten business days of completion of the onsite review.
5. **Decision and Notification to Involved Parties**
   a. If upon completion of the investigation of a deemed organization, ACHC identifies an IJ situation, CMS is notified as applicable. The Board Chair and Executive Management are also immediately notified.
   b. If sufficient evidence exists that the organization has violated ACHC Accreditation Standards, the organization may be placed Under Review.
   c. If an organization's accreditation is terminated, ACHC will notify CMS, as applicable, of the Termination. The organization will be removed from all listings of ACHC accredited sites.

**D. Non-Immediate Jeopardy – High**

Complaints and/or incidents are assigned this priority if the alleged noncompliance with the applicable ACHC Standard, if substantiated, would not represent an IJ, but would result in a determination of substantial noncompliance, i.e., at least one condition-level deficiency. An on-site survey is initiated within 45 calendar days of receipt of the complaint.

A formal written report is then prepared to reflect the above findings and submitted to ACHC within two business days of completion of the onsite review. Documentation is forwarded to and reviewed by the Clinical Compliance Department and Accreditation Review Committee and final report of findings is sent to the organization within ten business days of completion of the onsite review.

**E. Non-Immediate Jeopardy – Medium**

Complaints and/or incidents are assigned this priority if the alleged noncompliance caused or may cause harm that is of limited consequence and does not significantly impair the individual's mental, physical and/or psychosocial status or function. The incident or complaint, if substantiated, would not result in a determination of substantial non-compliance, (i.e., there would not be any condition-level deficiency). An

onsite survey must be scheduled no later than when the next onsite survey occurs, or one year after receipt of the complaint and/or incident, whichever comes first.

**F. Non-Immediate Jeopardy – Low**

Complaints and/or incidents are assigned this priority if the alleged noncompliance may have caused physical, mental and/or psychosocial discomfort that does not constitute injury or damage. In most cases, an investigation of the allegation can wait until the next onsite survey.

**G. Administrative Review/Off-Site Investigation**

This priority is used for complaints and/or incidents triaged as not needing an onsite investigation initially. This determination can be made through investigative action (written/verbal communication or documentation) initiated by ACHC to the provider to gather additional information that is adequate in scope and depth to determine that an onsite investigation is not necessary. ACHC has the discretion to review the information at the next onsite survey.

A fee will be processed for Administrative Review/Off-Site Investigations requiring a Plan of Correction (POC).

**H. Referral – Immediate**

This priority is used if the nature and seriousness of the complaint and/or incident or state/federal procedures require the referral or reporting of this information for investigation to another agency, without delay. This priority may be assigned in addition to one of the priorities listed above.

**I. Referral – Other**

Intakes are assigned this priority when referred to another agency or board for investigation or for informational purposes. This priority may be assigned in addition to one of the priorities listed above.

**NOTE:** If Clinical Compliance determines that the complaint does not involve patient care and the appropriate investigative method is through a request to the organization for documents, rather than a site visit, then ACHC sends the organization a written or verbal request for documents, including specific due dates for documentation. This action may be completed by the Quality Assurance or Clinical Compliance Department.